In the Supreme Court

Appeal from the Eaton Circuit Court
Hon. Calvin Osterhaven

ADVOCACY ORGANIZATION FOR
PATIENTS & PROVIDERS,

Plaintiff – Appellant

vs.

AUTO CLUB INSURANCE
ASSOCIATION, et al.,

Docket No. 124639

Defendants – Appellees

_____/

AMICUS CURIAE BRIEF OF
MICHIGAN HEALTH AND HOSPITAL ASSOCIATION
IN SUPPORT OF PLAINTIFF-APPELLANT'S BRIEF ON APPEAL

HONIGMAN MILLER SCHWARTZ AND COHN LLP
By: Chris Rossman (P25611)
Jason Schian Conti (P55617)
Cynthia F. Reaves (P63692)
Attorneys for Amicus Curiae
Michigan Health and Hospital Association
2290 First National Building
660 Woodward Avenue
Detroit, MI 48226-3506
(313) 465-7000

TABLE OF CONTENTS

Table of Contents (cont.)

TABLE OF AUTHORITIES

PAGE

FEDERAL CASES

MICHIGAN CASES

STATUTES

CENTERS FOR MEDICARE AND MEDICAID SERVICES MANUAL PROVISIONS

INDEX TRANSCRIPTS

STATEMENT IDENTIFYING JUDGMENT OR ORDER APPEALED FROM AND RELIEF SOUGHT

Amicus Curiae Michigan Health and Hospital Association supports Plaintiff-Appellant's request that the July 3, 2003 decision of the Michigan Court of Appeals in *Advocacy Organization for Patients & Providers v Auto Club Ins Ass'n*, 257 Mich App 365; 670 NW2d 569 (2003), be reversed.

QUESTIONS PRESENTED

Should this Court reverse the decision of the Court of Appeals which holds that the "reasonable" and "customary" charge language of Sections 3107 and 3157 of the Michigan No-Fault Automobile Insurance Act, MCL 500.3101 *et. seq.*, allows a no-fault insurer unilaterally and arbitrarily to determine that a charge is unreasonable if it exceeds a fee schedule, when the decision is clearly erroneous and conflicts with numerous decisions by the Court of Appeals that expressly prohibit no-fault insurers from paying providers according to fee schedules and specifically provide that the no-fault insurer is responsible for the customary charges of the provider?

Plaintiff-Appellant says "yes."

Amicus Curiae Michigan Health and Hospital Association says "yes."

Defendants-Appellees say "no."

Court of Appeals would say "no."

INTEREST OF AMICUS CURIAE MICHIGAN HEALTH AND HOSPITAL ASSOCIATION

The Michigan Health and Hospital Association ("MHA") is a nonprofit tax-exempt corporation whose members include numerous hospitals, health systems and other health care providers throughout Michigan. MHA acts as the principal advocate on behalf of hospitals,

health systems and other heath care providers on health care issues. In this capacity, MHA has frequently been called upon to express the views of its membership related to health care matters.

The issue presently pending before this Court is related to a no-fault insurer's obligation to pay the reasonable and customary charges of health care providers pursuant to Sections 3107(1)(a) and 3157 of the Michigan No-Fault Automobile Insurance Act (the "No-Fault Act"), MCL 500.3101 *et. seq.*, and specifically MCL 500.3107 and 500.3157, and is of great importance to the members of MHA. Further, the issue will have a profound impact on the delivery of health care services in the State of Michigan.

MHA's members regularly treat patients who are covered by insurance under the No-Fault Act. MHA believes that the viewpoint of its members will assist this Court in resolving the issues before it.

STATEMENT OF FACTS

MHA adopts the statement of facts set forth in the Plaintiff-Appellant's Brief on Appeal.

INTRODUCTION

The questions presented in this appeal involve the proper interpretation of the No-Fault Act. On August 20, 2003, the Court of Appeals published its opinion in *Advocacy Organization for Patients & Providers v Auto Club Ins Ass'n*, 257 Mich App 365; 670 NW2d 569 (2003), affirming the circuit court. Deciding *per curiam,* the Court of Appeals held that: (a) under the No-Fault Act, the customary fee that a medical provider charged did not constitute the reasonable fee to be paid by the insurer; (b) insurers did not tortiously interfere with providers' contractual relationships; and (c) providers failed to state a *prima facie* case for civil conspiracy. In so concluding, the Court of Appeals also ruled that no-fault insurers could determine the reasonableness of a charge based on whether the charge "does not exceed the highest charge for the same procedure charged by eighty percent of other providers rendering the same service" (the

"80th Percentile Test"). *Id.*, at 381-382. On May 14, 2004, MHA filed its amicus curiae brief in support of the Plaintiff-Appellant's application for leave to appeal to the Supreme Court. MHA now files this amicus curiae brief in support of Plaintiff-Appellant's brief on appeal.

The *Advocacy Organization* decision should be reversed because: (1) it directly conflicts with prior decisions of the Court of Appeals which prohibited no-fault insurers from paying health care providers according to fee schedules that the no-fault insurers unilaterally sought to impose, and upheld the right of the provider to bill its customary charges to no-fault insurers; (2) the record before the Court of Appeals was insufficient for it to determine whether the 80th Percentile Test is an appropriate measure of the reasonableness of a provider's charge; (3) the decision involves a fundamental change in the interpretation of the No-Fault Act that constitutes an impermissible amendment of the statute; and (4) the decision will cause material injustice to Michigan hospitals.

ARGUMENT

I. The *Advocacy Organization* Decision Conflicts With Prior Decisions Of The Court of Appeals, Is Clearly Erroneous, And Will Cause Material Injustice.

A. The *Advocacy Organization* Decision Conflicts With Prior Decisions Of The Court of Appeals.

The No-Fault Act provides that health care providers are reimbursed on the basis of their customary charges in cases not involving insurance. Section 3157 of the No-Fault Act provides that:

> A physician, hospital, clinic or other person or institution lawfully rendering treatment to an injured person for an accidental bodily injury covered by personal protection insurance, ..., may charge a reasonable amount for the products, services and accommodations rendered. The *charge shall not exceed the amount* the person or institution *customarily charges for like products, services and accommodations in cases not involving insurance.* MCL 500.3157 [emphasis added].

MHA argues that the No-Fault Act requires no-fault insurers to pay health care providers a reasonable amount for the products, services or accommodations rendered to persons covered

by personal protection insurance, and the only statutory limitation on the amount charged by a health care provider in such circumstances is the provider's customary charge for like products, services and accommodations in cases not involving insurance. MHA finds support for its position in a number of decisions of the Court of Appeals that have found that Section 3157 of the No-Fault Act is clear and unambiguous; under the statutory scheme providers are entitled to bill no-fault insurers their customary charges and no-fault insurers are prohibited from paying health care providers according to fee schedules that the no-fault insurers have unilaterally sought to impose. *See, e.g., Johnson v Michigan Mutual Ins Co*, 180 Mich App 314; 446 NW2d 899 (1989) (the Court of Appeals finds that Section 3157 permits health care providers such as Southfield Rehabilitation Hospital to charge reasonable amounts not exceeding their customary charges for the products, services and accommodations they provide to other injured persons in cases not involving insurance); *Hofmann v Auto Club Ins Ass'n*, 211 Mich App 55; 535 NW2d 529 (1995) (the Court of Appeals recognizes that the No-Fault Act does not permit a no-fault insurer to establish a dollar limit upon the amount it will pay to a doctor or hospital for services provided to no-fault insureds).

For example, in *Munson Medical Ctr v Auto Club Ins Ass'n,* 218 Mich App 375, 382; 554 NW2d 49, 52 (1996), the trial court concluded that Munson Medical Center had a legal right to payment in full of its "customary charges," which Munson Medical Center argued was the standard amount it bills on behalf of every patient treated, regardless of the fact that it routinely accepted less than this standard amount in many cases. 218 Mich App at 382. In that case, the insurer sought to utilize the workers compensation fee schedules to determine its liability to pay allowable medical expenses. The Court of Appeals, interpreting the same statutory scheme at issue in *Advocacy Organization*, agreed with the trail court and concluded that defendant Auto Club Insurance Association was "[u]nder this statutory scheme . . . required to pay the

'customary charges' for services rendered by Munson [Medical Center]." *Munson*, *supra* at 382. In *Bombalski v Auto Club Ins Ass'n*, 247 Mich App 536; 637 NW2d 251 (2001) the Court of Appeals observed that "the no-fault statute governed no-fault carriers' payments and required them to pay amounts customarily charged in cases not involving insurance." 247 Mich App at 545, n 3.

Under Michigan law: (1) a health care provider has the right to set the amount of its customary charges for medical services that it provides to all its patients, including the insureds of the no-fault insurers; (2) the provider is entitled to payment of these customary charges from no-fault insurers; and (3) such customary charges are not to be limited by fee schedules, however disguised, imposed by the no-fault insurers. The *Advocacy Organization* decision, however, contradicts the longstanding holdings of cases like *Johnson, Hofmann*, *Munson* and *Bombalski*. In *Advocacy Organization*, the Court of Appeals held that "the statute requires that an insurer only pay on behalf of the insured a 'reasonable charge' for the particular product or service. However, the Legislature has not defined what is 'reasonable' in this context, and, consequently, insurers must determine in each instance whether a charge is reasonable in light of the service or product provided." 257 Mich App at 379. Thus, the decision in *Advocacy Organization*, which allows the no-fault insurer to determine whether a provider's customary charge is reasonable, is contrary to the plain meaning of the statute and to prior decisions of the Court of Appeals which have upheld the right of the provider to bill its customary charges to no-fault insurers.[1]

B. The Approval Of The "80th Percentile Test" To Determine "Reasonable Charges" Under The No-Fault Act Is Clearly Erroneous.

---

[1] In their Motion to File Brief in Response to the Amicus Briefs of the Michigan State Medical Society and the Michigan Health and Hospital Association, Defendants-Appellees appear to rely heavily upon *Nasser v Auto Club Ins. Ass'n,* 435 Mich 33, 457 NW2d 637 (1990). MHA disagrees with the significance of the application of *Nasser* in the instant situation. *Nasser* does not address whether an insurer can pay less than customary charges, rather it speaks to whether an insurer is required to "cover" an expense. Further, *Nasser* does not provide that a no-fault insurer may impose unilaterally a fee schedule upon a hospital to determine whether the hospital's charges are reasonable.

(1) The "80th Percentile Test" Contradicts Prior Law.

The decision in *Advocacy Organization* permits the no-fault insurer to determine the reasonableness of a provider's charge based on whether the charge "does not exceed the highest charge for the same procedure charged by eighty percent of other providers rendering the same service" (the "80th Percentile Test"). *Advocacy Organization*, 257 Mich App at 381-382. According to the transcript of the deposition of an employee of Review Works, a review firm engaged by the Defendants-Appellees, under the 80th Percentile Test formula, the fees for those providers who charge at or below the 80th percentile are determined to be reasonable. *See* Deposition of Dianne Mateja, p67.[2] Under the 80th Percentile Test, assuming a group of 100 providers, all of the provider fees for a particular service during the course of a calendar year are theoretically "ranked" from high to low. That fee amount at which the 80th provider charges is the fee which the insurer determines to be "reasonable." *See* Deposition of Dianne Mateja, p67.

In application, the use of the 80th Percentile Test amounts to a fee schedule, since the Defendants-Appellees did not pay any charges in excess of the 80th percentile amount. Thus, the use of the 80th Percentile Test contradicts well-established law with respect to the use of formulas and fee schedules. Moreover, in approving the use of 80th Percentile Test, the Court of Appeals is approving a scheme that allows no-fault insurers unilaterally to determine whether a charge or group of charges are reasonable and the amount that they will pay providers for medical services provided to no-fault insureds. These types of determinations by no-fault insurers are prohibited by prior case law. *See Munson, supra, Hofmann, supra*, and *Mercy Mt Clemens Corp v Auto Club Ins Ass'n*, 219 Mich App 46; 555 NW2d 871 (1996) (holding that insurers could not utilize workers compensation fee schedules or amounts customarily accepted by hospitals from Medicare, Medicaid, Blue Cross Blue Shield and other insurers to determine

liability amount under the No-Fault Act). As the *Munson* court noted, "[w]hile health and accident carriers generally are free to [place dollar limits upon the amounts they will pay to doctors and hospitals for particular services], a no-fault insurer is not." *Munson, supra* at 384, quoting *Hofmann, supra* at 113, quoting *Auto Club Ins Ass'n v New York Life Ins Co*, 440 Mich 126, 139; 485 NW2d 695 (1992).

The Court of Appeals incorrectly approved the use of the 80th Percentile Test as a valid means of determining the reasonableness of a provider's charges for which a no-fault insurer will be liable. In support of the 80th Percentile Test, the Court of Appeals noted that the Defendants did not employ the worker's compensation payment schedule in determining whether a particular charge was reasonable; and the Defendants did not compare the payments made by other insurers as a basis of determining customary charges. *Advocacy Organization, supra* at 381-382. Such comparisons previously have been rejected by the Court of Appeals in *Munson, supra* (the Court of Appeals rejected the determination of payments based on the worker's compensation fee schedule) and *Hofmann, supra* (the Court of Appeals rejected the comparison of payments received from Blue Cross Blue Shield of Michigan). Thus, the Court of Appeals somehow concludes that the 80th Percentile Test is, in fact, different from the other fee schedules prohibited by the Court of Appeals in prior decisions. Nevertheless, the 80th Percentile Test is a fee schedule, and the use of fee schedules by no-fault insurers to limit payments to providers is contrary to established case law in Michigan. See *Munson, supra* and *Hofmann, supra*.

(2) The Record Does Not Justify The Reasonableness Of The "80th Percentile Test.

In *Advocacy Organization*, the Court of Appeals provides no justification in the record in support of the 80th Percentile Test, except for its summary conclusions that the 80th Percentile

---

[2] This transcript was filed in lower court as Exhibit S to Plaintiff-Appellant's Application for Leave to Appeal. A copy of the transcript is attached hereto as Exhibit A.

Test is somehow different from the fee schedules prohibited by the Court of Appeals in prior decisions. According to the Court of Appeals, while the defendant no-fault insurers (through themselves and through medical charge review companies) use a formula, such formula is based on a "survey of *charges* by other health-care providers for the same services." *Advocacy Organization, supra* at 382 (emphasis in original).

According to the Court of Appeals, such a ". . . sampling . . . is not prohibited by the statute for determining the reasonableness of charges for the same service." *Id.* The Court of Appeals, however, fails to explain why the survey taken of providers presents a valid formula for determining reasonableness. For example, the Court of Appeals fails to explain the scope of the survey or the sampling methodology; whether all providers are surveyed or just a select few to obtain comparable data; whether the surveyed providers are located in a common geographic area; whether the surveyed providers are of comparable size; and whether all surveyed providers admit and provide medical services to a comparable mix of insured, uninsured, Medicaid and Medicare patients. None of this data was present in the record before the Court of Appeals. There is no evidence in the record to substantiate that the 80th Percentile Test is not arbitrary and capricious, or completely inaccurate. The mere use of the phrase "80th Percentile" does not make the test statistically sound. Without evidence supporting the relevance and applicability of the 80th Percentile Test, the Court of Appeals should not have made any statement that could be construed as an approval of the test. Such an approval only sanctions further arbitrary and capricious failures to pay reasonable charges in the future. Because the Court of Appeals had insufficient evidence before it adequately to determine whether the 80th Percentile Test is an appropriate measure of reasonableness, the Court of Appeals' approval of the test is inherently unreasonable and should be reversed by this Court.

(3) The "80th Percentile Test" Is Arbitrary And Capricious.

The 80th Percentile Test is also arbitrary and capricious because it does not consider the legitimate variations in the costs of providing services between providers that influence the setting of their charges. These variations include the location of the provider, personnel expenses, the intensity of services provided, the presence or absence of a teaching program, capital costs, amount of indigent care provided and other unique expenses or unique factors of the particular provider. Providers, in determining and setting their customary charges, take these and other factors into account, and the customary charges set by each provider are the best measure of what is a reasonable charge. For example, the factual record demonstrates that the providers which are included in the "survey of charges" upon which the 80th Percentile Test is based, are drawn from the entire State of Michigan. *See* Deposition of Dianne Mateja, p72. Given the diversity of the various regions of the state, it is highly probable that the charges of providers will vary substantially based upon geographic information, patient-mix and other variables. These variables are not considered under the 80th Percentile Test, and, consequently, the 80th Percentile Test is arbitrary and capricious and is therefore, inherently unreasonable.

(4) The Approval Of The 80th Percentile Test Is An Impermissible Amendment Of The No-Fault Statute.

The legislative history of the No-Fault Act does not support the Court of Appeals' interpretation of the statute. For example, in 1992, Defendant Automobile Club Insurance Association ("ACIA") supported passage of a referendum that appeared on the November 3, 1992 ballot and was soundly rejected: Proposal D, which would have permitted ACIA to pay no-fault claims according to fee schedules.[3] Again in 1993 and 1994, ACIA unsuccessfully supported passage of similar amendments which would have expressly incorporated the worker's

[3] Proposal D was defeated by a margin of almost 100,000 votes. *See*, 1993-1994 Michigan Manual, at p. 878.

compensation fee schedules into the No-Fault Act.[4] The *Munson* court found that despite the failure of ACIA to obtain amendments, ACIA unilaterally implemented the use of workers' compensation fee schedules. The Court of Appeals in *Munson* rejected ACIA's attempt to limit its payments to a fee schedule and rightly held that in paying no-fault claims, the "use of criteria imposed by other statutory schemes or contractual agreements is hereby rejected as a matter of law." *Munson, supra* at 390.

It is a well-settled notion that the courts are bound by the plain language of a statute and legislative amendments are necessary to alter existing law. *See, e.g., Cherry Growers, Inc v Agricultural Marketing and Bargaining Bd*, 240 Mich App 153, 173; 610 NW2d 613, 623 (2000); *Michigan v Stephan*, 241 Mich App 482, 508; 616 NW2d 188, 201-202 (2000). Generally, no-fault insurers are not permitted under existing law to unilaterally limit their payments to providers. *See Munson, supra, Hofmann, supra,* and *Mercy Mt Clemens, supra.* Any such change to the statutory scheme would require a legislative amendment. As the *Munson* court set forth, ACIA, after several failed attempts to support statutory amendments, improperly attempted to achieve the same results unilaterally via its own payments to providers. *Munson, supra.*

The decision in *Advocacy Organization*, which allowed the no-fault insurer unilaterally to set a "reasonable" charge based on a maximum fee schedule generated through the 80th Percentile Test, is contrary to the legislative history and settled interpretation of the No-Fault Act, and is an impermissible attempt by the Court of Appeals to amend the statute. As such, the *Advocacy Organization* decision must be reversed by this Court.

---

[4] The amendments were enacted in the 1993 legislative session as 1993 PA 143 ("Act 143"). *See*, 1993 Journal of the House at 478-479. As a result of a petition drive, Act 143 was placed on the 1994 general election ballot as Proposal C and the effective date of Act 143 was suspended. *See*, Insurance Bureau Bulletin 93-159218-M (December 22, 1993). Proposal C was defeated by 646,794 votes. *See*, 1995-1996 Michigan Manual at p. 995. Act 143, therefore, did not take effect. *See, Munson, supra*, at 387 n. 4 ("1993 PA 143 became Proposal C, which was rejected in the November 1994 general election).

C. The Advocacy Organization Decision Will Cause Material Injustice To Hospitals.

The Court of Appeals' decision in *Advocacy Organization* will also cause material injustice to Michigan hospitals because the decision will place the hospitals at risk of violating Medicare program requirements and jeopardize the financial stability of the hospitals.

(1) The Court Of Appeals' Decision In *Advocacy Organization* Is Contrary To The Principles Of Medicare Reimbursement.

The Court of Appeals' decision in *Advocacy Organization* is also contrary to the principles of Medicare reimbursement applicable to hospitals that participate in the federal Medicare program and the State of Michigan's Medicaid program. The complex federal and state laws and Medicare regulations and guidelines lead to the practical requirement that each hospital that participates in the Medicare and Medicaid programs maintains a uniform charge schedule that is applied to all patients. In that regard, Section 2203 of the Centers for Medicare and Medicaid Services Provider Reimbursement Manual ("PRM") provides, in part, that "each facility should have an established charge structure which is applied uniformly to each patient as services are furnished to a patient and which is reasonably and consistently related to the cost of providing the services." In order to comply with this directive of the Medicare program, a hospital's charge schedule (*i.e.*, its customary charge for a specific service) is likely to reflect the hospital's reasonable cost of providing a specific service.

Further, PRM § 2604.3 provides that a provider's "customary charges" are "those uniform charges listed in a provider's established charge schedule which is in effect and applied consistently to most patients and recognized for program reimbursement." In other words, the Medicare program requires that all patients (both Medicare and non-Medicare) must be charged the same amount for identical services (*i.e.*, the provider's customary charge for a particular service). However, a provider may agree by contract or otherwise to accept payment for services

based on contractual allowances or discounts negotiated with private payers or at rates imposed by government payors such as Medicare or the Michigan Medicaid program.

Uniformity of charges for all patients is required in cost reports submitted by Medicare participating hospitals to the Centers for Medicare and Medicaid Services ("CMS"), an agency of the US Department of Health and Human Services ("HHS") that is responsible for administration of the Medicare program. CMS has issued thousands of pages of regulations and related interpretive guidelines governing Medicare's reasonable cost reimbursement system. *See, Shalala v Guernsey Memorial Hosp*, 514 US 87, 96 (1995) (noting that as of 1993, the Medicare regulations "consumed some 620 pages of the Code of Federal Regulations." Currently, the Medicare regulations consume more than 1,500 pages of the Code of Federal Regulations.)

The uniform charge requirement appears in PRM Section 2203, which states, in part:

> To assure that Medicare's share of the provider's costs equitably reflects the costs of services received by Medicare beneficiaries, the intermediary, in determining reasonable cost reimbursement, evaluates the charging practice of the provider to ascertain whether it results in an equitable basis for apportioning costs. So that its charges may be allowable for use in apportioning costs under the program, *each facility should have an established charge structure which is applied uniformly to each patient* as services are furnished to the patient and which is reasonably and consistently related to the cost of providing the services. [Emphasis added.]

The requirement that hospitals report uniform charges in their Medicare cost report has been upheld in numerous federal cases addressing Medicare reimbursement disallowances. *See, e.g., Lake Region Hosp Corp v Heckler*, 602 F Supp 109, 111 (D Minn 1983) (the court notes that the Medicare program requires hospitals to report charges in a uniform manner for cost reporting purposes because the charge figure affects the amount of cost reimbursement), *St Mary's Hosp Medical Ctr v Heckler*, 753 F2d 1362, 1364 (CA 7 1985) (without uniformity of charges Medicare would bear a heavier burden for the cost of lab services), and *Baptist Memorial Hosp v Sullivan*, 1992 WL 314081 (WD Tenn 1992) (Secretary of HHS requires uniformity of reported price charged to ensure proper cost apportionment).

Because of the Medicare rules described above and the lengths to which CMS has gone to enforce such rules, hospitals routinely develop and maintain uniform charge schedules applicable to all patients. The Court of Appeals' decision in *Advocacy Organization,* which requires hospitals to develop a second charge schedule applicable only to services provided to no-fault insureds, will require hospitals to deviate from this practice and creates a conflict with Medicare program requirements. Such a result should not be permitted by this Court.

(2) The Court Of Appeals' Decision In *Advocacy Organization* Provides No-fault Insurers With The Benefit Of A Bargain To Which They Are Not Entitled.

Payments to providers for a particular service can vary among a range of payors due to allowances or discounts that are agreed upon by both the provider and the payor. For example, providers are free to choose to participate in the Medicare and Medicaid programs, and those that do must accept the limited reimbursement provided by such government programs. Providers also can choose to enter into contractual arrangements with private insurers that provide the insurers allowances and discounts from the provider's customary charges. If a no-fault insurer desires to contract with a provider for discounted rates, it is free to do so; however, no-fault insurers should not be permitted to benefit from a discount or allowance that is unilaterally imposed upon a provider by application of the 80th Percentile Test.

The *Advocacy Organization* decision allows no-fault insurers to reimburse a provider at a rate which has been discounted without the consent and agreement of the provider. This is fundamentally unfair to the provider. The No-Fault Act should not be interpreted in a manner that would allow no-fault insurers to impose the benefit of a contractual discount on providers in the absence of any such contractual arrangement. Such a result is contrary to the bedrock principle of American contract law that parties are free to contract as they see fit. *See, e.g., Burkhardt v Bailey*, 260 Mich App 636; 680 NW2d 453 (2004). Instead, in the absence of any

such bargained-for benefit, simple contract law requires that providers are entitled to their customary charges, the same charges any other patient or payor would pay in the absence of a contract providing otherwise.

II. The Issue Of Whether The "80th Percentile Test" Is A Valid Measure Of The Reasonableness Of A Provider's Charges Was Not Before The Court Of Appeals In *Advocacy Organization.*

The issue of whether the 80th Percentile Test is a valid determination of the reasonableness of expenses incurred by a no-fault insured and to which a no-fault insurer is liable, was not explicitly before the Court of Appeals in *Advocacy Organization*. The issue before the Court of Appeals on appeal was whether, under the language of the No-Fault Act, "defendant insurance companies are required to pay the full amount charged as long as the charge constitutes a 'customary' one, or if defendants are entitled to independently review and audit the medical costs charged to their insureds to determine whether a particular charge is 'reasonable.'" *Advocacy Organization, supra* at 372. The Court of Appeals has answered this question in the affirmative, and MHA vigorously asserts that its answer is incorrect.

The Court of Appeals, however, improperly went on implicitly to approve the 80th Percentile Test as a means of determining reasonableness:

> [D]efendants Auto Club Insurance Association (ACIA) and Review Works, for example, employ the "80th percentile test." Under this test, ACIA and Review Works recommend payment of one hundred percent of the charges as long as the charge does not exceed the highest charge for the same period *charged* by eighty percent of the other providers rendering the same service. Thus, although defendants ACIA and Review Works use a formula, the formula is based on a survey of *charges* by the other health-care providers for the same services, a sampling which we conclude is not prohibited by the statute for determining reasonableness of charges for the same service.

Advocacy Organization, supra at p382 (emphasis in original).

The Court of Appeals ruling, if allowed to stand, will impermissibly give the green light to no-fault insurers and medical charge review companies to use the 80th Percentile Test and

establish fee schedules. The Court of Appeals should only address and consider those issues that are properly brought before it on appeal. The Court of Appeals' approval of the 80th Percentile Test will have far-reaching consequences as it will undoubtedly be used by no-fault insurers in making determinations of the reasonableness of providers' charges. Thus, the improper approval of the 80th Percentile Test by the Court of Appeals in *Advocacy Organization* must be reversed.

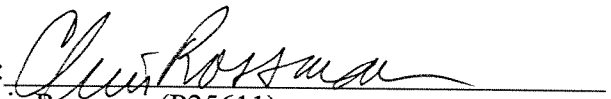
RELIEF REQUESTED

Amicus Curiae MHA respectfully requests that this Court reverse the Court of Appeals' decision in *Advocacy Organization.*

Respectfully submitted,

HONIGMAN MILLER SCHWARTZ AND COHN LLP
Attorneys for Amicus Curiae
Michigan Health and Hospital Association

Dated: August 20, 2004

By: 

Chris Rossman (P25611)
Jason Schian Conti (P55617)
Cynthia F. Reaves (P63692)
2290 First National Building
660 Woodward Avenue
Detroit, MI 48226-3583
(313) 465-7000

INDEX OF EXHIBITS

INDEX TRANSCRIPTS

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

COPY

CONFIDENTIAL
DEPOSITION OF DIANNE MATEJA, R.N. - JULY 22, 1997

File No. 5:96-CV-177 Hon. R. Bell

ADVOCACY ORGANIZATION FOR PATIENTS AND PROVIDERS, a non-profit Michigan corporation; GORDON ALLEN, P.T.; BRADLEY BENGSTON, M.D.; RICHARD A. BEREZA, M.D.; JOHN BRUDER, M.D.; EDWARD BROPHY, D.O.; RONALD CLARK, M.D.; A. GEORGE DASS, M.D.; DON DAVIS, M.D.; MICHAEL DORSEY, M.D.; MICHAEL FITZSIMMONS, M.D.; FRED M. HANKIN, M.D.; THOMAS HAVERBUSH, M.D.; BRUCE HENDERSON, M.D.; JOHN HOGIKYAN, M.D.; CHESTER R. HOYT, M.D.; GERALD JERRY, JR., M.D.; PAUL KENYON, M.D.; BERT J. KORHONEN, M.D.; ROBERT KREITSCH, M.D.; ANDREA KULDANEK, M.D.; NORMAN LICHT, M.D.; DAVID LINT, M.D.; BARRY McALPINE, D.C.; JOSEPH McGRAW, M.D.; KENNETH MERRIMAN, M.D.; DAVID MICHAEL, D.O.; STEPHEN MONTES, D.O.; W. DAVID MOORE, M.D.; EDWARD J. NEBEL, M.D.; RAYMOND NOELLERT, M.D.; LARRY PACK, M.D.; ALAN PLONA, M.D.; VINCENT R. PRUSICK, M.D.; STEVEN RINGLER, M.D.; PAUL E. ROOSE, D.O.; PETER ROSENBAUM, M.D.; DIANA ROTHMAN, M.D.; MARK RUSSELL, D.O.; PHILIP SORENSEN, M.D.; KENNETH STEPHENS, D.O.; DAVID SWASTEK, M.D.; JAMES TELFER, M.D.; GREGORY M. UITVLUGT, M.D.; DAVID A. VANDER WALL, M.D.; NORMAN WALTER, M.D.; EDWARD WASHABAUGH, M.D.; KENTON WATERBROOK, D.O.; BARRY WICKSTROM, M.D.; MARK WILSON, M.D.; JOHN COLVIN, Guardian to Tim Colvin; and DEBRA McGORON, Guardian to Johnny Brown,

Plaintiffs,

-vs-

AUTO CLUB INSURANCE ASSOCIATION, a Michigan corporation; ALLSTATE INSURANCE COMPANY, an Illinois corporation; CITIZENS INSURANCE COMPANY OF AMERICA, a Michigan corporation; FARM BUREAU INSURANCE COMPANY, a Michigan corporation; FARMERS INSURANCE EXCHANGE, a California corporation; FRANKENMUTH MUTUAL INSURANCE COMPANY, a Michigan corporation; IMPERIAL

Page 62

inputted into your system and that's used to do the various kinds of analyses we talked about before, whether it's necessary, whether it's gone on too long, whether it's related, and then whether there's a modifier to the code, whether the code was billed incorrectly and has to be changed, and then after all that's done you come out with a charge for a code?

(Discussion off the record.)

BY MR. HOFFMAN:

Q. Now let's concentrate on an example of a charge.

MR. MANDEL: Was there an answer to the last question?

THE REPORTER: Yes, I think so.

THE WITNESS: I don't think there was.

THE REPORTER: Let me check to be sure. No, you're right, there wasn't.

MR. HOFFMAN: Why don't you read the question back, then?

(Reporter read back question page 61, line 25 through page 62, line 8.)

THE WITNESS: We would come out with what we would recommend as payment for that code.

Page 63

BY MR. HOFFMAN:

Q. All right. Now, let's assume that the whole process has gone through and now you've come out with a doctor's got a diagnostic code that -- well, he's -- you've determined that the code has been correctly applied and there's a charge for the code. Now, your system compares that provider's charge for that code to the charges of other providers for the same code; is that right?

A. Yes. Yes, that's how we determined the 80th percentile.

Q. And by 80th percentile, stop me if I'm wrong, but my understanding is you'll go to your database, and let's assume there are 100 providers in your database that have billed for that identical code, and your computer program selects -- orders those charges in order from lowest to highest; is that right?

A. The computer program doesn't do that.

Q. Okay.

A. It doesn't print them out that way.

Q. How do you derive the 80th percentile, then?

A. The 80th -- we look at all of the codes at least annually, some of them we look at more often, the high volume codes, and we print out -- we can input the code that we want for the time frame that we want it, and it will print out all of the codes that were billed within that time frame underneath that code with all of the fees and then the computer does the 80th percentile calculations, and how it would do that would be out of 100 providers it would line them all up, but it doesn't print them that way. I didn't want you to think that. And where the 80th one bills is what it determines is the 80th percentile.

Page 64

Q. Okay.

A. It also gives the low, the high, and the average on the report.

Q. I guess what I'm hearing is that you annually do a review of the charges in your database to set the 80th percentile for the next year, is that --

MS. BUSH: I'd object to the extent the question mischaracterizes her testimony. She said with the exception of high volume codes.

MR. HOFFMAN: Okay.

THE WITNESS: They're at least done annually, though.

MS. BUSH: Okay.

Page 65

THE WITNESS: At least done annually. Some are done more often.

BY MR. HOFFMAN:

Q. And I'm just trying to focus on -- so let's take one particular code. When you are setting the recommended reasonable compensation for that code, you do that at least annually, correct?

A. That's correct.

Q. For every code?

A. Yes.

Q. Let's leave aside the codes that you do more than annually now and just focus on one code for -- the charge for one code. What data do you use to derive that recommended reasonable charge for that particular code?

A. We use the previous year's data.

Q. Okay.

A. What we have at that time.

Q. So if you're setting the recommended compensation on January 2nd, you will use the database that goes back for the year previous to that?

A. Well, we start in January to do all the codes. We go from 1-1 the year before to 12-31 of

Page 67

the year before.
Q. Okay.
A. And we use those dates. Whether we happen to be doing that particular code on January 1st or January 12th or February 16th, we still use the 1-1 to 12-31. It would be just too hard to keep track of it any other way.
Q. Okay. So for the period 1-1 to 12-31 you go back and take all the charges for that code for that year in your database?
A. That's correct, that are unmodified.
Q. That are unmodified. And you'll order those charges in rank from lowest to highest?
A. They do not come out in rank from lowest to highest. They print out as we got them in by federal ID number, so they don't come out lowest to highest on the reports.
Q. Well, I'm not -- what does the computer program do?
A. It calculates the 80th percentile, but it's probably smarter than people so it doesn't have to print them in order to figure it out.
Q. Well, I guess the 80th percentile is not 80 percent of what the provider charges, is it?
A. No. The 80th percentile is where the 80th provider charged out of however many there are.
Q. Well --
A. So if there are 400 providers, the 80th percentile is 320.
Q. I know you don't physically print out an ordering of the charges, I'm not saying that, but when you're saying it's the -- for example, to use your example of 400 providers have charged for this code and you take the 320th, that's the 320th from the lowest on a spectrum to the highest, right?
A. That's correct, but it doesn't print that way.
Q. Okay. That was what was confusing me. Now, suppose the 330th provider billed the same as the 320th provider, what would the system evaluate as the reasonable charge?
A. It would all be the same. The 80th percentile can be the same as the 50th percentile, the 80th percentile can be the same as the 100th percentile. You know, normally you see a normal bell curve, but there certainly are cases in which the percentiles go over a spread.
Q. What were the factors that led you to

Page 68

adopt this method of evaluating the charges for procedure codes?
A. When we began the no-fault program?
Q. Correct.
A. In the early nineties there was -- there was still -- amongst the health reimbursers in the country percentiles were probably still the most widely used methodology of reimbursement. We were just beginning to see relative value units and relativity scales used.
Q. Was the percentile method kind of the industry standard at the time?
A. The percentile method was the most widely used standard at that time in general terms. You know, we were starting to see the HMOs become more active, they use percentiles but they use them for different things, and -- but at that time percentiles were certainly the most common used and they were the easiest for people to understand.
And they really -- the percentile structure really gives the onus back to the providers. You know, they control their own destiny somewhat. They have more control over their destiny than the payor portions of the

Page 69

industry do.
Q. And that is because the way the system operates depends on what providers in the database actually in the real world charge for their services?
A. That's correct, but it still leaves the destiny lying with the provider community. You know, if you look at the pot of how health care is administered in this country, we have the patient, we have the provider, and we have the payor. And the provider determines what he wants to charge, and there, you know, with the exception of some workers' comp statutes and Medicare, they can charge whatever they want. They could charge a thousand dollars to take out a splinter, that's their right.
And then you have the payor part of the community who has to determine what they're willing to reimburse for that procedure, and that could be in a variety of methods, it could be contractual so that they have to accept it, but the providers determine their own destiny with percentiles because if they don't think they're making enough money they can just keep raising their charges, and since most reimbursers go back

Page 70

a year for the previous year's data, they can raise their rates annually that way.
Q. It sounds to me what you're describing is kind of an industry-wide ability of the providers to, as you put it, control their own destiny?
A. That's -- I'm talking about the provider community controlling it.
Q. An individual provider that's out of step with his community and is billing above the 80th percentile will have his charge challenged by the system?
A. More often, yes.
Q. Do you have any estimate of the percentage of provider charges that are for procedure codes, and I'm again after all the utilization analysis is done, that are paid in full under this system?
MR. GLAZEK: We've been talking about nonhospital-based providers throughout this, right, just so that's clear?
BY MR. HOFFMAN:
Q. Is there a difference between hospital-based providers and nonhospital-based providers?
A. Not if they bill on HCFA forms, but we're

Page 71

not talking about reimbursement of facilities here, which would be hospitals themselves, they're considered a facility.
Q. And they don't bill on HCFA forms?
A. Not generally. They bill on UB-92s.
Q. Okay. But the hospitals may have providers or physicians who bill on HCFA forms, and this no-fault analysis system that you've been describing does apply to those physicians?
A. Yes, it does.
Q. Does your program --
A. I didn't -- I wanted to ask you to rephrase the previous question, though.
Q. Do you have an estimate of what percentage of the provider bills that are subjected to the 80th percentile analysis are paid in full?
A. Well, at least -- theoretically at least 80 percent of the provider bills are paid in full. Generally it's higher than that. And we did do some studies about out of, you know, a dollar that we recommended not be paid to a carrier only about seven cents -- seven to eight cents of that dollar comes from a reduction because of a fee analysis to a particular

Page 72

procedure code.
MR. GLAZEK: Could you repeat that answer again? I'm sorry.
THE WITNESS: For 1996 about seven cents out of every dollar that we recommended not be reimbursed for a variety of reasons, about seven cents out of a dollar was because of an actual fee reduction for a particular procedure code. It's very small.
BY MR. HOFFMAN:
Q. So the other reductions in the no-fault area that your program generates relate to all the other things that we were talking about that happen before the 80th percentile analysis is applied, and that's utilization review, necessary, excess utilization, and all that, and 93 percent of your recommended reductions in charges relate to all the other stuff that comes before the application of the 80th percentile?
A. That's correct.
Q. Where do you draw your database from for the annual, or in some cases more than annual, analysis of the 80th percentile?
A. We use the entire state of Michigan for that.

Page 73

Q. And do you use actual provider bills for that?
A. Yes.
Q. And are these bills that come through your system?
A. Yes.
Q. How is Review Works compensated for its review of provider bills for customers?
A. We are paid by the line, so when a provider bills, if they bill for five things on a bill, then we get paid for five lines.
Q. So the provider bills come through on a HCFA form?
A. That's correct.
Q. And each particular procedure code will be billed on one line?
A. That's correct.
Q. And you charge per line?
A. That's correct.
Q. If you approve all the lines and all the codes made by the provider and approve it to be paid 100 percent, you get paid the same amount per line?
A. Yeah. It doesn't matter whether we approve it, not approve it, approve it in part, we

Page 78

A. It's called the reconsideration process. On the front of the EOB that is sent -- that is supposed to be sent to the physician with his check, sometimes they send it before or after the check, but it says on there if they want to make -- if they want to appeal the decision or ask for reconsideration, they're to send it, and it's got a phone number and an address, and we ask that it be done in 30 days. We don't hold anybody to 30 days but -- we've taken them much longer than that. So sometimes they call and they fax them, sometimes they write to us, sometimes they just write a note on the EOB and put it in the mail. We take them in a variety of ways.

Q. What procedure is followed at Review Works if you receive a request for reconsideration from a provider?

A. Then it goes to the reconsideration process, and there they can go in and they print out a form, it either approves the reconsideration in full, approves it in part, or denies it altogether.

Q. What might the reconsideration process consist of in a particular case?

A. You know, a lot of it could be that the

Page 79

provider billed the wrong code to begin with, so that's why the reimbursement was, you know, not as much as they thought it should have been, so now they're sending us documentation to support that, you know, it was really a six inch laceration and not a two centimeter laceration. Some of them could be that maybe we said that something appeared to be unrelated and now they've sent documentation that said, Well, yeah, I know you would normally not pay for this test but we needed to do this test because we were going to take them to surgery the next week. You know, there could be a variety of things. Some of them are fee related, some of them have to do with lengths of treatments that are related that they may have information that we didn't have or, you know, it could be a variety of things.

Q. Do you have any estimate on the volume of requests for reconsideration that you receive?

A. It's pretty low. I think it's less than two percent of the things come back for reconsideration.

MR. McINTYRE: The time frame here, Mr. Hoffman?

MR. HOFFMAN: Pardon me?

Page 80

MR. McINTYRE: Can we get a time frame on that estimate? Are we talking '92, '98?

MR. GLAZEK: The two percent figure.

MR. HOFFMAN: Oh, two percent.

THE WITNESS: Oh, gosh, that would be just the last time that I studied it and -- I could do that kind of analysis and provide it to Cheryl by the year if that's something that somebody wants.

MR. HOFFMAN: Is that all right, Cheryl?

MS. BUSH: Well, we can talk about that later.

MR. HOFFMAN: Okay.

BY MR. HOFFMAN:

Q. Now, there's a feature of the system called the PPO or preferred provider organization aspect of the system?

A. Yes, that's another component.

Q. Could you describe that?

A. We have a contractual arrangement with a network, the Medview Network, in which providers --

MR. GLAZEK: I'm sorry, what's the name?

Page 81

THE WITNESS: Medview. In which providers agree to take dollar amounts less than they billed and they contract for it.

BY MR. HOFFMAN:

Q. And that has to do with the -- a contract between the provider and Medview?

A. Right, that they will take 80 percent of R and C or, you know, 90 percent of R and C, that they'll accept a lesser rate than the reasonable, customary rates.

Q. So some providers have contractually agreed to take a certain percentage of what is analyzed as the 80th percentile, right? Is that right?

A. That's correct.

Q. Now, do all your carrier customers participate in this PPO system?

A. No.

Q. Some do and some don't?

A. That's correct.

Q. So you really can't generalize about how the PPO system applies across the board, it just depends on each individual carrier?

A. It would depend on each individual carrier and where each individual carrier's book

Page 82

of business happens to be. You know, some carriers might have a higher penetration of use in that network than another carrier.

Q. That's very difficult to make any general statements about that aspect of the situation?

A. Yes.

Q. Does the Review Works system get into the issue of coordination of no-fault insurance with other health care insurance?

A. We are currently doing that, yes.

Q. Is this a new aspect of the system?

A. Yes.

Q. Now, how does that operate? What factors does the program analyze with regard to charges in the area of coordination with health care?

A. If a person has purchased a coordinated policy from their auto carrier and they have health insurance, then we would finish the whole bill review process, and a lot of times the EOBs from the health carriers are attached to the bills, you know, that's how the providers send them.

Q. EOB is explanation of benefit form?

A. Right, be it the Blue Cross explanation of benefit or American Community or whomever it

Page 83

is. If the doctor is participating, then we would determine if there were to be any payment made at all by the auto carrier, which is generally just co-pays and deductibles, what the -- you know, like let's say a doctor billed $100, and we recommended payment of the $100 and the health carrier approved $80 and then paid 80 percent of $80, which would be $64. If the doctor was participating in that health group they -- we would only make recommendation of then a $16 payment to make up the difference between 64 and 80. Did I get that right? I hope so. If the doctor doesn't participate, then we would recommend a payment level between the 64 and the 100.

Q. Okay. So let's use Blue Cross/Blue Shield for an example.

A. Okay.

Q. If the doctor is participating again and there's a co-pay in effect, okay, Blue Cross/Blue Shield for this particular procedure will allow a charge of $80 of which they will pay 80 percent of $80, correct?

A. Correct.

Q. And the doctor then may bill the no-fault

Page 84

carrier $100, which he deems his normal charge for the procedure?

A. That's correct.

Q. If the doctor is participating in Blue Cross/Blue Shield, he is not permitted to charge the no-fault carrier more than $80 because that's under the Dean case, I believe.

MS. SILSBURY: On a coordinated policy you're talking about?

MR. HOFFMAN: Right. Well, no.

BY MR. HOFFMAN:

Q. Now, I don't think it's a -- my understanding is a doctor is a participating Blue Cross doctor. Blue Cross has a fee schedule that they compensate doctors on, correct?

A. That's correct.

Q. If he's a participating doctor he has contractually agreed to accept $80 as the compensation for the procedure that he does?

A. That's correct, on a Blue Cross insured.

Q. On a Blue Cross insured. Now, okay, I see --

A. So they have --

Q. -- Ms. Silsbury's point.

A. So they can do coordinating. They have

Page 85

to have a coordination.

Q. But even if it wasn't coordinating wouldn't he still be limited to charging the no-fault carrier $80 because that's what he's contractually agreed was his charge with Blue Cross/Blue Shield?

A. I don't know. I don't know how he could impose his contract if the patient doesn't have health insurance through Blue Cross, but I'm not an attorney so...

Q. Okay. Well, let's use -- the system operates for no-fault policies that are coordinated?

A. That's correct.

Q. Okay. And if it's -- if the doctor is participating, you'll pay the co-pay but no more?

A. We -- the total reimbursement can't be any more than Blue Cross approves for that --

Q. Right.

A. -- procedure code.

Q. But if -- if he's nonparticipating and it's coordinated, then he's entitled to charge his reasonable and custom -- his reasonable fee even if that's in excess of the Blue Cross/Blue Shield fee schedule?